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NURSING HOME CARE: THE UNFINISHED AGENDA

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PREPARED BY THE STAFF OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

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PREFACE

The report herein contains the findings of a two-year investigation by the Special Committee on Aging into the quality of care provided in this Nation's nursing homes. Our conclusions are based on extensive interviews with patients, nursing home personnel, government officials, and other experts, in addition to a careful analysis of federal inspection reports over the past five years.

What we found is that thousands of our oldest, sickest citizens live in nursing homes which more closely resemble 19th century asylums than modern health care facilities. We've allowed bed, board, and abuse to replace the medical and rehabilitative care the law demands.

Each year, 1.5 million Americans spend time in nursing homes at an annual cost of more than $30 billion--about half of which is paid by Medicare and Medicaid. To be eligible for government money, nursing homes must comply with certain "conditions of participation" and undergo periodic inspections to prove they continue to "substantially" meet these conditions.

Committee findings show that almost one-third of the Nation's 8,852 skilled nursing facilities failed to meet at least one basic federal standard to assure the health and safety of residents in 1984. Almost a thousand failed to meet three or more such standards. A substantial number of these homes are chronic offenders, repeatedly defying federal regulations and subjecting thousands of older Americans to inadequate care and squalid conditions.

Our report finds that there has been a dramatic increase in violations of major conditions, including a 75 percent increase in failure to provide physician supervision for patients and a 61 percent increase in failure to provide 24-hour nursing care. Despite the high number of violations, the federal government claims to have decertified only 200 nursing homes in 1985.

This report establishes that our current systems of inspection and enforcement are incapable of assuring that residents actually receive the high quality care the law demands. Congress must act to effectively strengthen these systems and underscore the rights of patients to appropriate, quality care.

JOHN HEINZ
Chairman

Staff Report

United States Senate
Special Committee on Aging
John Heinz, Chairman

NURSING HOME CARE: THE UNFINISHED AGENDA

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NURSING HOME CARE: THE UNFINISHED AGENDA

Staff Report

Special Committee on Aging

United States Senate
John Heinz, Chairman

EXECUTIVE SUMMARY

INTRODUCTION.

This report summarizes the findings of a two year investigation by Committee staff. In the course of this investigation, interviews were conducted with nursing home residents and their families, facility employees and managers, and attorneys and researchers involved with quality assurance in nursing homes., In addition, Committee staff consulted with dozens of State and Federal officials who are responsible for monitoring and enforcing minimum standards for safe and high quality nursing home care.

Committee staff analyzed Federal data depicting the quality of care in the Nation's Federally certified nursing homes, and selected a sample of these facilities for in-depth examination of hard copy inspection reports covering a period of five years. Published research and court filings were reviewed, as well as internal documents from State and Federal governmental agencies.

BACKGROUND:

Federal, State and private spending for nursing care adds up to more than $30 billion per year. Total annual expenditures from private sources is over $15 billion, Medicaid spends more than $14 billion yearly, and Medicare, approximately $650 million. On any given day, 1.5 million patients occupy beds in the nation's 15,000 nursing homes.

Nursing homes seeking Medicare or Medicaid funding must meet certain "Conditions of Participation." These "conditions" represent minimum federal standards for nursing care and physical environment. They include: (1) patients must not be subjected to mental and physical abuse; (2) each patient must remain under the care of a physician who must periodically review the patient's total plan of care and must sign all orders for treatment; (3) the nursing home must provide 24-hour service by licensed nurses; (4) the facility is required to ensure that patients receive adequate nutrition and assistance with feeding where needed; (5) drugs can only be administered by physicians, licensed nurses or trained personnel approved by the state; (6) the nursing home must maintain adequate conditions relating to environment and sanitation.

WHAT ARE THE PROBLEMS IN NURSING HOME CARE?

PROBLEM #1: Tens of thousands of patients in nursing homes still suffer from the poor nutrition, inadequate nursing care, and squalid conditions thought to have been corrected long ago by State and Federal reforms.

- Nursing home inspection reports reveal that in 1984 over one-third -- 3,036 of the nation's 8,852 certified skilled nursing homes -- failed to fully comply with the most essential health, safety, and quality standards of the Federal government.

- Nursing home inspection reports reveal that in 1984 about 1,000 (11%) of certified skilled nursing homes were cited for violating three or more critical minimum standards for hea th and safety,

this despite the fact that nursing homes often have advance notice of an inspection and, thus, are able to prepare ahead of time and conceal or temporarily correct major deficiencies.

PROBLEM #2: Federal inspection reports show that between 600 and 800 certified "skilled nursing" homes in the U.S. chronically fail year after year to meet minimum quality standards.

- o The HHS Inspector General has found that 740 SNFs chronically fail to meet key quality care requirements. Using narrower and more conservative standards, Committee staff estimate that 582 facilities are chronically substandard.
- o The existance of an alarming number of chronically substandard nursing homes suggests the enforcement system is seriously deficient and ineffective.
- o HCFA has failed to use data at its disposal to identify and take action against chronically substandard nursing homes.
- o One reason for poor quality is inadequate and poorly targeted reimbursements by Medicaid/Medicare, which forces some nursing home operators to "cut corners" on care.

PROBLEM #3: Finding a nursing home at all, let alone one that offers quality care, is extremely difficult and is a process over which the consumer has little or no control.

- o A serious shortage of nursing home beds exists in many communities, the effects of which are felt primarily by Medicaid eligible patients, those who will shortly spend down and become Medicaid eligible, and those with heavier care needs. (The Inspector General of DHHS has recommended that the current excess of hospital beds be used to help alleviate the shortage of nursing home beds nationwide.)
- o Greater pressure is placed on patients to find a nursing home because many hospitals have responded to the incentives of the Medicare prospective payment system (PPS) by encouraging earlier discharge.
- o Some nursing homes take advantage of the tight bed supply in their communities by illegally extorting financial gratuities from relatives of patients seeking admission to a nursing home.
- o The result of the tight bed supply is that substandard homes continue to attract patients for lack of any alternative.

PROBLEM #4: The Department of Health and Human Services (DHHS) has failed in its Congressionally mandated responsibility to ensure that nursing homes receiving Federal funds provide high quality medical and rehabilitative care.

- o The 10th Circuit Court of Appeals ruled in a landmark decision in October 1984 that the DHHS enforcement mechanism assures only "paper compliance" with the nursing home quality standards of the Social Security Act.
- o DHHS, thus far, has made only limited improvements in the enforcement system, and has failed to propose many necessary reforms.

PROBLEM #5: Existing Federal penalties for use against substandard nursing homes are ineffective in that they limit the number of enforcement actions that can be taken against substandard nursing homes, and expose residents to serious risks from transfers.

- o A full array of "intermediate sanctions", or penalties, short of cutting off all Federal reimbursement to the residents of a nursing home, has not yet been enacted by Congress.

- o Lacking a Federal receivership authority, whereby enforcement officials appoint a temporary "master" to take over the operation of decertified nursing homes, enforcement officials can only "protect" frail patients from poor care by forcing them to move out of the nursing home.

STAFF RECOMMENDATIONS

Federal Legislation and improved regulation are needed to:

- o strengthen the nursing home inspection system;

- o mandate improved State response to consumer complaints and requests for inspection and cost reports;

- o require the Secretary to report to Congress within 2 years with a recommendation for a case mix reimbursement system for Medicaid nursing home services, including a recommendation for how to meet the needs of patients who will be displaced from nursing homes as case mix reimbursement improves access for a large number of heavy care patients;

- o authorize a full array of "intermediate sanction" penalties and a receivership authority, so a measured, incremental enforcement approach can be taken by inspectors, and substandard homes can be improved without relocating all the residents of these facilities;

- o elevate the nursing home residents' rights to a Condition of Participation, and strengthen these rights; make providers liable for civil penalties for certain acts of Medicaid discrimination now enforceable only as crimes;

- o strengthen the national long term care ombudsman program.

In addition to the above legislative and regulatory changes, the following administrative actions should be undertaken:

- o HCFA should expand the hospital swing-bed program, to (1) ease the tight bed supply situation that facilitates illegal discriminatory practices; (2) increase competition in the industry, so quality can be more of a factor in the marketplace.

- o HCFA should issue instructions to the State agencies and HCFA regional offices, informing them of their obligation to enforce existing laws, such as (1) penalties for repeat offenders; and (2) prohibitions against Medicaid discrimination.

- o HCFA should promptly define what minimum items and services are meant to be provided under the basic daily Medicaid rate in each State, to protect residents' personal funds and to protect providers from unreasonable reimbursement rates.

NURSING HOME CARE: THE UNFINISHED AGENDA

A Staff Report

Special Committee on Aging
United States Senate

John Heinz, Chairman

May 21, 1986

NURSING HOME CARE: THE UNFINISHED AGENDA

A Staff Report of the Senate Special Committee on Aging

United States Senate
John Heinz, Chairman

INTRODUCTION.

This report summarizes the findings of a two year investigation by Committee staff. In the course of this investigation, interviews were conducted with nursing home residents and their families, facility employees and managers, and attorneys and researchers involved with quality assurance in nursing homes. In addition, Committee staff consulted with dozens of the State and Federal officials responsible for monitoring and enforcing minimum standards for safe and high quality nursing home care.

Committee staff studied Federal data depicting the quality of care in the Nation's Federally certified nursing homes, and selected a sample of these facilities for in-depth examination of hard copy inspection reports covering a period of five several years. Published research and court filings were reviewed, as well as internal documents from State and Federal governmental agencies.

BACKGROUND.

Federal, State, and private spending for nursing home care adds up to more than $30 billion per year. Total annual expenditures from private sources is over $15 billion, Medicaid spends over $14 billion yearly, and Medicare, approximately $650 million. On any given day, 1.5 million nursing home patients occupy beds in the nation's 15,000 nursing homes.

THE FEDERAL NURSING HOME ENFORCEMENT SYSTEM.

Nursing homes seeking Medicare or Medicaid funding must meet certain "Conditions of Participation." These "conditions" represent minimum Federal standards for nursing care and physical environment.

Roles Of The Federal And State Agencies.

The Health Care Financing Administration (HCFA), Federal funding agency for Medicare and Medicaid, relies upon State agencies and surveyors (inspectors) to enforce the Federal standards through periodic inspections. Federal regulations provide that a nursing home found to "substantially" meet Federal minimum standards can be "certified" to care for Medicare and/or Medicaid beneficiaries.

State survey agencies are required to inspect nursing homes annually to determine whether the facilities are in compliance with as many as 541 standards and requirements pertaining to the level and quality of care, staffing and environment. Examples of the major 20 or 30 standards and requirements critical and essential to maintaining a minimally acceptable level of care are:

1. Patients must not be subjected to mental and physical abuse, nor to (except in emergencies) chemical and physical restraints without a physician's order;

2. Each patient must remain under the care of a physician who must periodically review the patient's total plan of care and must sign all orders for treatment;

3. The nursing home must provide 24-hour service by licensed nurses sufficient to meet the total nursing needs of all patients;

4. The facility is required to ensure that patients receive adequate nutrition and assistance with feeding where needed;

5. Drugs can only be administered by physicians, licensed nurses or trained personnel approved by the state, and cannot be administered without a physician's written order; and

6. The nursing home must maintain adequate conditions relating to environment and sanitation.

The Certification Process.

The federal certification program recognizes two types of nursing homes: (1) Skilled Nursing Facility (SNF) for patients with heavy care needs; and (2) Intermediate Care Facility (ICF) for patients with relatively lighter care needs.

A nursing home may seek certification for either or both Medicare and Medicaid programs. Only SNFs can be reimbursed by Medicare. HCFA reviews State survey agency recommendations, but makes its own determination whether a SNF qualifies for Medicare reimbursement. State survey agencies themselves determine whether a nursing home is qualified to be reimbursed by Medicaid. Medicaid reimburses both SNFs and ICFs.

The State survey agencies, also known as State licensing and certification agencies, are under contract by HCFA to perform two types of annual surveys (inspections), the certification survey and the inspection of care. Both survey and inspection reports are open to public scrutiny.

Federal regulations permit recertification of a nursing home with some deficiencies so it may continue to receive reimbursement from both Medicare and Medicaid. The State, however, must find that the deficiencies "do not jeopardize patient health and safety, nor seriously limit the facility's capacity to give adequate care." A large number of nursing homes are certified under these provisions each year.

When a facility is certified under these rules, the State "agency must maintain a written justification of these findings" that the patients are not in jeopardy. In addition, the nursing home must submit an adequate plan which indicates the deficiencies will be corrected no later than one year after the inspection. If the same deficiency is present during a later inspection, the nursing home cannot be certified for Medicare or Medicaid participation unless it was in compliance "at some time during" the period since the first inspection, "made a good faith effort" to comply with minimum standards, and "was unable to do so for reasons beyond its control".

The only alternative action left to the State under existing Federal regulations is to decertify facilities that fail to meet conditions of participation (for SNFs) and standards (for ICFs). When a nursing home is decertified, all Medicare and Medicaid beneficiaries must be transferred elsewhere.

HCFA performs validation surveys on facilities surveyed by the State agencies to assure that the State process is adequate to guarantee that certified facilities do meet the Federal Conditions of Participation.

The administrative complexity of the overall Federal quality enforcement system for Medicare and Medicaid arises to a large extent from the long-standing view of many Federal officials that Medicaid is a "State" program, whereas Medicare is viewed as a "Federal" program. The Federal government, however, is ultimately accountable for the functioning and efficacy of the Medicaid quality assurance program (please see discussion below regarding the duty of the Secretary of Health and Human Services to assure quality care in nursing homes.)

WHAT ARE THE PROBLEMS IN NURSING HOME CARE?

PROBLEM #1: Tens of thousands of patients in nursing homes still suffer from the poor nutrition, inadequate nursing care, and squalid conditions thought to have been corrected long ago by State and Federal reforms.

Horror stories in nursing homes are thought by many to be rare occurrences, isolated in number and, for the most part, relegated to history. Unfortunately, this is an untrue perception; an alarming number of nursing homes continue to provide grossly inadequate care resulting in humiliation, suffering, and premature death. To establish the depth and severity of persistently dangerous and unhealthful conditions in Federally approved and certified nursing homes, several case histories are appended to this staff report [please see Appendix A].

Nursing home inspection reports reveal that in 1984 over one-third of the nation's certified nursing homes failed to fully comply with the most essential health, safety, and quality standards of the Federal government.

A Federal database containing findings from nursing home inspection reports was analyzed by Committee staff with the assistance of GAO and the Inspector General of HHS. A list of "critical" health and safety standards -- those most directly related to patient well-being in Skilled Nursing Facilities -- was developed by Committee staff in consultation with GAO and the IG, based upon a similar list developed by the Health Care Financing Administration (HCFA) to identify seriously deficient nursing homes. 3,036 skilled nursing homes (34% of a total of 8852) failed to fully comply with these critical standards in 1984. The same database revealed that 987 (11%) certified nursing homes were cited for violating three or more of these critical minimum standards for health and safety during 1984. [Please see Appendices B through E].

The Committee staff estimate is conservative because the Federal database underreports the extent of substandard care being provided in nursing homes on a daily basis: (1) nursing homes know when the inspectors are coming and are able to present to inspectors conditions that are not representative of an average day at the facility; and (2) violations of critical standards identified during several thousand of the more recent inspections have not yet been added by HCFA to the database.

There is evidence to show that some nursing homes are able to predict with great accuracy the impending "unannounced" inspections by State certification teams. The daughter of one resident, who visited her mother in the nursing home 2 or 3 times each day, said

> "They seem to know when the inspections are coming. I was there so often that I could tell what was coming just by the way they were making preparations. For example, the rehabilitation nurse said [they should] put her in a wheelchair for one hour every day with a posey restraint and a back brace. But they wouldn't use the restraint. I told them 'use the restraint, it's in the record'. They checked the record, then put a strap on her! There was no brace. They left her for 3 hours. She was really hurting when they put her in bed. But when [the State] was coming in, all the patients would be up in wheelchairs, and my mom would be up with a posey [restraint] on properly."

Internal memoranda from one chronically substandard nursing home on nursing staff meetings contain numerous references to upcoming inspections:

March 9, 1983 "...the [inspection] report were [sic] an improvement over previous ones. Most felt relieved since everyone had worked so diligently to accomplish the goal....[the nursing home] passed the

survey....Efforts will be made to avoid a crash effort to prepare for future inspections."

September 14, 1983 — "Survey Team is here to check skill care units [sic]. They will return at a future date to survey [another unit]. It was expected that they would survey both areas at this time but there is a difference in cancellation date."

November 2, 1983 — "Survey Team...[m]ay visit any day. Our main concern is to maintain certification."

May 2, 1984 — "The [State] Survey is expected to be in depth and the special projects hangs on the result of the survey."

October 4, 1984 — "State Survey Team is still expected."

February 6, 1986 — "Surveys. Two surveys between now and May: [1.] The Post-Survey [and] [2.] The Annual Survey due in May."

February 20, 1985 — "Post survey is due in May. This survey will deal with deficiencies found last May. Don't know who will do post survey since they have different teams."

Moreover, according to a February 12, 1986 report by the Inspector General ofDHHS, the inspection report database is incomplete because of poor management by HCFA in the past. In January 1985, IG auditors identified 3,849 nursing home providers in the database for which no inspection findings were recorded for 15 months or more -- in apparent violation of the law which requies annual inspections of nursing homes. Upon further checking, however, the IG learned that 96% of these facilities had actually been inspected, but the results simply had not yet been entered into the database. When the IG auditors doublechecked the completeness of the data base in late October 1985 to see how much progress HCFA has made in reducing the backlog, there were still 3,842 providers with no inspection results for the past 15 months or more.

PROBLEM #2: Federal inspection reports show that almost a thousand certified "skilled nursing" homes in the U.S. chronically fail year after year to meet critical quality standards.

At the request of the Chairman of the Committee, the Inspector General for DHHS analyzed the HCFA database to determine the extent of chronically substandard nursing home care. In a draft report dated November 12, 1985 the IG noted,

> "...we selected [32] of the over 500 standards/elements we felt were most related to patient care. We designed computer programs to identify facilities that failed: [1] a selected condition of participation for two or more consecutive years, [2] three or more selected conditions of participation in any of the last three most recent surveys, [3] any one of the selected conditions of participation two or more times, [4] any one of the selected standards three or more consecutive times. There were [740 skilled nursing homes] that failed one or more of our parameters. We selected a number of these providers in various States to verify the data....Our review showed that the facilities we identified were in fact problem providers who over the course of the past several years showed patterns of noncompliance with important conditions of participation." [Please see Appendix F].

In order to isolate and tabulate the very worst of the repeat offenders, Committee staff analyzed the HCFA database to determine how many nursing homes had violated three critical health and safety standards on

three or more inspections out of the most recent four on-site surveys. 582 facilities, or approximately 6.6% of all SNFs, were identified as providing grossly and chronically deficient care to residents. [Please see Appendices B and D]

The existance of an alarming number of chronically substandard nursing homes suggests the enforcement system is seriously deficient and ineffective.

A great deal of attention has been given to the problem of appropriately measuring quality of care in nursing homes [please see Problem #4, below]. The fact that Federal inspection reports themselves can be used to identify almost a thousand certified nursing homes as chronically substandard suggests that the Federal system has failed, not only in measuring poor quality care, but in doing something about it. Subsequent sections of this report address some of the specific barriers to enforcement that prevent the system from assuring quality care.

HCFA has failed to use data at its disposal to identify and take action against chronically substandard nursing homes.

While the problem of chronically substandard nursing homes has long been understood by long term care ombudsmen and State officials, HCFA has done remarkably little to identify these facilities and take action against them.

In 1981 and 1982, HCFA had recognized the value of its inspection report database to analyze the "track records" of individual nursing homes. The agency proposed to identify the best nursing homes in the country, and to subject them to inspections only once every two or three years. The plan was dropped after consumers and the Congress pointed out defects with the plan, in part because the information in the database lagged too far behind actual inspections to be relied upon to identify good nursing homes.

Nonetheless, the HCFA database, even without timely updating, is very useful for identifying repeat offenders in the Federal system: while their most current performance rating is not currently maintained in HCFA's database, their history is a matter of record. Such providers could be targeted for increased scrutiny, as some of the Medicare Peer Review Organizations (PROs) now use much smaller databases to identify providers that should be subjected to intensive review of cases and claims.

Another use for the database could involve examining patterns of State enforcement agency noncompliance with Federal law, such as failure to inspect nursing homes annually. The Inspector General recommended that HCFA use their data for both these purposes.

HCFA, however, has not utilized the database in this way. The Inspector General's report on this subject notes:

> "Contrary to HCFA's conclusion that [the database] is efficiently meeting its objectives, our surveys in the eight HCFA regional offices show that [the database] is not an effective management tool....Results of facility surveys which are required to be performed annually are not input...timely; thus, the system's output is out of date....HCFA regional officials perceive this to be a major deficiency within the system",

and do not use the system to monitor nursing homes or State agencies.

The IG report recommends that the database "be updated and kept current and that it be the basis for HCFA's management decisions regarding surveys and certifications of long-term care facilities. In this regard, we are recommending that a national strategy by developed using [the database] to [h]one in on long term care facilities that have not

been surveyed within regulatory time frames or have exhibited aberrant patterns of care."

<u>One reason for poor quality care is inadequate and poorly targeted reimbursements to some facilities by Medicare and Medicaid, which force some nursing home operators to "cut corners" on care.</u>

A nursing home administrator testified on October 24, 1985 before the Committee that Medicare reimbursement to nursing homes does not fully cover the cost of providing care to the new, sicker population being discharged from hospitals under PPS for skilled nursing care. As a result, the administrator could take few very heavy care patients. One reason for this problem may be Medicare's dependence on a facility's cost history in setting reimbursement rate ceilings. A rapid change in patient mix, such as has occurred with the rapid influx of heavier care patients since PPS was implemented, can cause costs to rise faster than reimbursement.

Under the Medicaid program, Congress has given the States a great deal of flexibility to determine reimbursement levels for nursing homes, but clearly required that the reimbursement be sufficient:

> "A State plan for Medical assistance [Medicaid] must ... provide for payment of the [nursing home] ... through the use of rates ... which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable ... quality and safety standards...." [Social Security Act Sec. 1902(a)(13)(A)]

Nursing home industry representatives have provided the Committee with examples of lawsuits filed and won by the industry in States where reimbursement was inadequate to meet the mandate of Congress.

Yet, while the law may provide relief in egregious examples of inadequate Medicaid reimbursement, it seems certain that the present two-level (SNF and ICF) payment scheme fails to fully account for differences in the severity and extent of individual patients' illnesses. A reimbursement scheme more sensitive to differences in patients' needs is needed.

In addition, there is no minimum Federal definition of what services a Medicaid beneficiary in a nursing home can expect to receive from the nursing home. Based upon reports that patients' meager personal funds were being charged for basic services meant to be covered by Medicaid reimbursement, Congress in 1977 required the Secretary to define which nursing home items and services are covered by the Medicaid program. The Medicare/Medicaid Anti-Fraud and Abuse amendments gave the Secretary 90 days after enactment to come up with a minimum list of services covered by Medicaid's nursing home benefit, but this has not been done.

<u>PROBLEM #3</u>: Finding a nursing home that offers quality care is extremely <u>difficult</u>, and is a process over which the consumer has little or no control.

The search for a nursing home bed more often than not is very complicated and a draining experience, emotionally and financially, for both the patient and family. This difficulty is severe enough to have spawned a new industry of professional consultants, "bedhunters," who charge a fee for finding a nursing home bed.

Misinformation, as well as the lack of information, also takes a heavy toll on the inexperienced in the search of a nursing home. For example: a survey by the American Association of Retired Persons (AARP) showed that 79% of its members mistakenly believe that Medicare pays for a large portion of nursing home costs when, in fact, the coverage is very small (only about 2%); seldom are patients and their families aware of the the assistance and information that they may obtain free of charge

from federally funded ombudsmen; the nursing home consumer is even less familiar with federal law which prohibits such practices as discrimination against Medicaid-eligible patients; and, virtually all new users of nursing home care are totally unaware state inspection reports on facilities are public documents.

In the course of the investigation, Committee staff learned of examples of relatives being frustrated by additional barriers, including:

- o policies at some State licensing and certification offices to keep inspection reports in only one location in the State, thus forcing interested parties to travel great distances to review it, and
- o inappropriate State agency limitations and delays in response to requests by the public for access to such reports.

Medicare's new prospective payment system (PPS), with its financial incentives for hospitals to discharge patients sooner, has increased time pressures in the search for a nursing home.

A large number (a third or more) of patients are discharged to the nursing home from a hospital with a physician's order or recommendation for nursing home care. The Committee's 1985 hearings into the impact of PPS on quality and access to long term care demonstrated, however, that many hospitals have poor discharge planning and will notify the patient just hours before their impending discharge that they must leave right away. This process leaves little or no time for the hospital discharge planner, patient or family to "shop" for a "good" nursing home. In this case, the "search" is almost invariably reduced to accepting whatever is available, and any consideration of whether the nursing home offers high quality care is lost.

Many communities suffer from a serious shortage of nursing home beds, which is felt most harshly by Medicaid-eligible patients.

There actually are two nursing home markets: one for private pay patients who pay the highest nursing home rates; and a second market for Medicaid-eligible and near-poor patients. Private pay patients, who are charged premium rates by nursing homes, can afford to "shop" for quality. Medicaid patients, who bring the nursing home lower reimbursement rates for care, have less buying power. Consequently, the Medicaid patient often must settle for whatever bed may be available and without quality considerations. Traditional marketplace pressures in most industries serve the valuable function of keeping product quality high. This, however, is not necessarily the case in the Medicaid market of the nursing home industry where the provider can expect to keep beds filled with Medicaid patients even if quality is poor.

A 1983 General Accounting Office study identified the Medicaid-eligible elderly population as suffering disproportionately from a lack of access to nursing home beds. A later report, "Expanding The Swing-Bed Provisions of The Omnibus Reconciliation Act of 1980," by the DHHS Inspector General states:

> "most experts agree that currently there are serious shortages of nursing home beds throughout the country -- estimates range into the hundreds of thousands -- and ... this condition can be expected to worsen."

The IG's 1986 report noted that "Medicare and Medicaid patients are most adversely affected by the bed shortages" and cited reasons for this bed shortage:

- A rapidly growing aged population, particularly the oldest aged -- persons over 85 -- who tend to need nursing home care most often.

- Nursing home construction has not kept pace with increased demand brought about by the aging of the population, in part because of State restrictions on new construction.

Both the 1983 GAO and 1986 IG reports agree that the number of patients "backed up" in hospital beds awaiting discharge to a Skilled Nursing Facility is a valid indicator of access problems. GAO observed this problem was most severe for Medicaid patients with heavy care needs.

The Inspector General of HHS has recommended that the current excess of hospital beds be utilized to help alleviate the shortage of nursing home beds nationwide.

The Inspector General's report recommends that HCFA expand the scope of its "experiment" with swing-beds (unused beds) in hospitals, so that hospitals in urban areas with a shortage of nursing home beds, and an excess of hospital beds, can be paid to care for skilled nursing patients in a hospital. According to the IG, there are approximately 148,500 "excess hospital beds" in the U.S., that could potentially be used to alleviate the current nursing home bed supply shortage.

The IG report argues that if these existing beds were to be used for nursing home care, instead of building 148,500 new nursing home beds, Medicare and Medicaid would realize savings of some $1.9 billion from the "avoided construction of nursing homes". In addition, hospitals would be able to recoup some of their costs of maintaining the empty excess hospital beds, estimated by the IG at some $5.3 billion annually to maintain. This strategy, however, will address only a small portion of the total need for new nursing home beds, estimated by sources cited in the IG report as approximately 600,000 new beds by 1990 -- some 450,000 more than the estimated number of empty hospital beds available for conversion to swing-beds.

It is unlikely, however, that the new beds needed to meet this remaining demand will be built. The Aging Health Policy Center, cited in the IG report, reached this conclusion after reviewing the tight fiscal constraints on Federal and State spending for Medicaid. Nursing home costs now account for as much as 2/3 of some State Medicaid budgets, and have been targeted by States for many years as an area for cutbacks and cost control.

Restrictive State certificate of need policies were cited as a major cause of the slow rate of construction of new nursing home beds, as States seek to restrain rising Medicaid expenditures by constraining the supply of beds. Nine States, according to the IG, have placed a moratorium on new nursing home construction.

In addition, ombudsman advocates in some States have reported that nursing home owners oppose the construction of new beds. Providers already in the market have little incentive to seek expansion of bed supply through new construction for the following reasons:

- o Nursing home corporations have been able to expand by purchasing hundreds of existing facilities each year.
- o As new beds come on the market, occupancy rates would drop -- pinching profitability by raising fixed costs per patient.
- o With reduced occupancy, owners would no longer have as much ability to "pick and choose" the wealthiest patients from the pool of prospective patients. Instead, they would need to accept all candidates to keep occupancy levels as high as possible in the newly competitive market.

The Inspector General's new proposal to expand the hospital swing bed program faces likely opposition from nursing home interests for these reasons.

Some nursing homes take advantage of the tight bed supply in their communities by illegally extorting financial gratuities from relatives of patients seeking admission to a nursing home.

Witnesses at hearings before the Committee in October 1984 and October 1985 testified that many nursing homes engage in a variety of illegal and questionable practices, such as:

- o A former admissions director from a mid-size nursing home chain testified before the Committee on October 1, 1984 that she was ordered by the owners to maintain two waiting lists, one for private pay patients and one for Medicaid eligible patients. She was instructed to admit private pay patients ahead of Medicaid patients, no matter how long the Medicaid patients had been waiting for admission.

- o Refusing to admit, or threatening to evict, a Medicaid eligible patient unless and until s/he agrees to pay a substantial amount of money up front or on a monthly basis. Payments were identified ranging from up front payments of few thousand dollars to tens of thousands of dollars.

- o Requiring that every Medicaid patient have a "guarantor" to pay for items or services provided by the facility to the patient, but not reimbursed under the Medicaid program.

- o When patients have spent down all their money and they must rely upon Medicaid to pay for their care, some facilities move them to less desireable locations in the nursing home.

These practices are widespread, resulting in action by several Attorneys General and State governments (including CA, MD, MI, NY, OH, WA, and WI) to serve notice on the nursing home industry that criminal and or civil prosecution may result.

To date, there has been no concerted action by the Department of Health and Human Services to identify and correct these practices. The HHS Office of Inspector General has referred cases to one or more U.S. Attorneys for criminal prosecution, but reported to the Committee that the U.S. Attorneys have opted not to prosecute any of these cases.

The widespread belief that Medicaid is a State program, to be policed by State officials, has been a significant barrier to achieving concerted Federal action to eliminate forms of Medicaid discrimination prohibited under the Social Security Act.

PROBLEM #4: The Department of Health and Human Services (DHHS) has failed in its Congressionally mandated responsibility to ensure that nursing homes receiving federal funds provide high quality medical and rehabilitative care.

Despite a 1984 Federal Appeals Court order to promulgate regulations for ensuring "high quality medical care" in nursing homes, the Department has instituted only limited reform and improvement in the enforcement system.

The landmark decision, issued by the 10th Circuit Court of Appeals, grew out of a suit filed by a group of Colorado nursing home patients in 1975. The patients had contended that the enforcement system that had been developed by the Secretary of DHHS was "facility-oriented," not "patient oriented" and thereby failed to comply with federal law.

In its October 1984 opinion, the Federal Appeals Court concluded:

"failure to promulgate regulations that allow the Secretary to remain informed, on a continuing basis, as to whether [nursing homes] receiving federal money are meeting the requirements of the [law,

> including providing high quality patient care], is an abdication of the Secretary's duty."

The DHHS responded to the Court's order by promulgating regulations for a new type of nursing home inspection, first known as the "Patient Care and Services" survey and later renamed the "Long-Term Care Survey Process (LTCSP)". The new survey process has undergone pilot trial in a handful of facilities in each of 47 States and, after several delays, is scheduled to be fully implemented in July 1986.

The LTCSP places far more emphasis on quality of care andpatient outcomes than does the existing survey and compliance system. Nonetheless, LTCSP has drawn substantial criticism for lacking in a number of areas. For example, the recently published report, "Improving the Quality of Care in Nursing Homes," by the Institute of Medicine (IOM) lists five "major problems" with the new survey system. They include: (1) "the conditions and standards *** remain oriented toward facility and capability and do not include quality-of-life factors"; (2) LTCSP lacks "a formal protocol for sampling of residents for detailed reviews of caregiving"; (3) the new process "still relies on unguided surveyor judgement to make the important decisions of whether care problems demonstrated by a facility constitute deficiencies"; (4) LTCSP "procedures do not require the facilities to maintain standard resident assessment data"; and (5) the new system "does not integrate the [LTCSP] survey with the inspection-of-care (IOC) [inspection]."

The director of Washington State's Bureau of Nursing Home Affairs, Conrad Thompson, contends that LTCSP has "fundamental flaws." According to Thompson, in order for the new system to be "a valid and reliable process," it needs: "[1] inclusion of a standardized patient assessment process; [2] development of a statistically valid sampling methodology; [3] proper training for [State] surveyors; and [4] stronger focus on resident rights, the physical plant environment and administrative responsibility."

Rehabilitation Care Consultants, Inc., a private firm hired by HCFA last year to analyze and evaluate pilot trials of the new survey process, issued its final report in November 1985. Among the firm's findings was that there appeared to be "a wide variance in how individual states decided upon what to cite as deficiencies, what not to cite, and what to label as recommendations." The report stated:

> "It became clear that all states do not agree as to whether surveyors are to act as consultants or enforcers. For example, several states cited deficiencies that in other states were presented to the facilities as recommendations."

This very same problem of variance among states on what to cite and what not to cite as being deficient has plagued the existing survey process.

On April 9, 1986 twenty national organizations, lead by the National Citizens' Coalition for Nursing Home Reform (NCCNHR) and including organizations representing the nursing home industry, urged the Department to establish a reasonable phase-in period for implementation, to improve initial and follow-up training, revise guidelines for inspectors, and allow States to establish innovative inspection procedures under waiver.

Critics of the new LTCSP survey system all seem to agree that HCFA must place far more emphasis on oversight of state survey agencies and especially on the training of the surveyors themselves. To date, HCFA has taken the position that the new survey process should be implemented first, and changed later to meet these concerns.

Preliminary findings of a study conducted for the Committee by the General Accounting Office provide additional evidence to show that enforcement is inadequate. In a statement prepared for the Committee's

nearing record, GAO was critical of HCFA for having made only "limited use" of the "repeat deficiency" regulation.

This regulation requires that before a State can recertify for Medicare/Medicaid reimbursement a "repeat offender" nursing home (i.e. one that has violated a health and safety standard twice or more), the State must first determine that the facility did comply with the standard at some point during the past year, made a good faith effort to come into compliance prior to failing the same standard for a second time, and that reasons for the second failure were beyond the nursing home's control.

GAO reviewed the certifications of 10 "repeat offender" nursing homes and found that had not undergone the review required by the repeat deficiency regulation. The GAO report to the Committee states:

> "Our work to date has provided indications of uncertainty and lack of agreement among state and HCFA regional personnel in applying the repeat deficiency regulations *** HCFA regional office officials told us that repeat deficiency regulations generally are not being applied by states or by HCFA *** [I]t appears that HCFA needs to more clearly enunciate agency policy regarding repeat deficiencies and provide additional guidance and assistance to the states and HCFA regions in interpreting and applying the repeat deficiency regulations."

PROBLEM #5: Existing Federal penalties for use against substandard nursing homes are ineffective in that they limit the number of enforcement actions that can be taken against substandard nursing homes, and expose residents to serious risks from transfers.

Decertification is the only Federal penalty presently available to HCFA and the State certification agencies for use against a nursing home that fails to meet Federal health and safety standards. Decertification is analogous to shutting the nursing home down, in most cases where it is invoked, because facilities typically cannot afford to operate without the reimbursement from Federal programs. This is because, on any given day, about two-thirds of all nursing home patients are Federal beneficiaries, accounting for about half of the average facility's revenue.

Decertification is rarely used as a penalty. The following table depicts the number of involuntary terminations for violations of health and safety standards, by year.

INVOLUNTARY TERMINATIONS OF NURSING HOME CERTIFICATION

	1980	1981	1982	1983	1984	1985*
Total Number Terminations	90	48	41	27	40	24
Total Number SNF Terminations	45	26	10	7	11	3

*Note: Data for 1985 are incomplete due to slow input of data by States and HCFA Regional Offices.

The Institute of Medicine of the National Academy of Sciences observed in its recent report on nursing home care "[b]ecause of the undesirability of closing facilities and relocating residents, states rarely terminate" providers from Federal programs. A broad consensus of

State regulators and long term care advocates agree that relocating residents of nursing homes is a remedy that causes problems of its own.

One nursing home patient interviewed by Committee staff was relocated from the Pennsylvania nursing home he lived in for years. He returned from the local senior center one day to be informed by an aide that she had "bad news" -- he would have to move out. Facility employees packed his belongings that night, and moved him out the next day. In the chaotic transition from the closing nursing home to another facility across town in an unfamiliar neighborhood, the ambulance drivers became lost, and the patient had to direct them back to their starting point. In addition, this patient lost $1800 in personal funds, along with other residents' money held by the facility, because the nursing home had closed down without paying back the residents' monies. Because he is a Medicaid eligible patient, he had no choice in the nursing home he was moved to. According to local sources, his new home is "one of the worst in town" and has been in trouble with the State.

Congress recognized that decertification is a crude tool to use on substandard nursing homes, when legislation was adopted in 1980 creating the "Alternative to Decertification" authority. The new law authorized the Secretary and the State certification agencies to impose a moratorium on future admissions of Federal beneficiaries at substandard nursing homes. By preventing new admissions, the enforcement officials can protect patients not now in the facility from being admitted into substandard conditions, while lessening the burden of new admissions on the nursing home. In addition, the moratorium can amount to a financial penalty if the facility does not improve swiftly.

The Federal authority is meant to be used on facilities that are substandard, but which are not so poor as to require decertification. For facilities that are to be decertified, the moratorium must be invoked immediately. Several States have a similar authority now, according to the Institute of Medicine's recent poll of State certification agencies. In one State, however, the authority is only used when license revocation is proposed, and so cannot be viewed as an "intermediate" penalty.

The Office of General Counsel of DHHS ruled after Congress created the moratorium on admissions authority that regulations would be needed to implement the new law. In 1983, constituents made the Committee Chairman aware of persistently substandard conditions in a Pennsylvania nursing home, where the moratorium on admissions penalty could usefully be imposed. A series of letters and meetings followed between December 1983 and the Summer of 1985, wherein Committee staff expressed to the Department the need for prompt issuance of the regulation and made suggestions for improvements. In November 1985, at the Chairman's request, the Inspector General recommended to HCFA that similar changes to those suggested by the Committee be made in the proposed moratorium on admissions authority. Issuance of the revised the regulation is reportedly a high priority of the new Secretary of HHS.

State licensing and certification officials support the development of a full range of Federal penalties for use against providers that violate minimum health and safety standards. Although many State legislatures have enacted a variety of penalties or "intermediate sanctions", few States have the flexibility they need to respond appropriately to substandard care. In Washington State, according to Conrad Thompson, chief of licensing and certification, several such authorities have been enacted. Yet he reports the State is unable to respond fully to chronically substandard nursing homes without a receivership authority. By appointing a receiver or "master" to operate a nursing home that is being decertified, enforcement officials can begin immediately to improve care for the residents without the chaos and disruption engendered by relocation of residents. The temporary operator appointed by the State leaves when a satisfactory permanent owner or manager can be approved by the State.

By making decertification a more practical sanction, receivership should enable States to decertify facilities. Some version of this authority exists in many States, including Arizona, California, Colorado, Connecticut, Florida, Illinois, Iowa, Kansas, Maryland, Minnesota, Missouri, New Jersey, New York, Oklahoma, Pennsylvania, and Wisconsin.

Sandra Casper, R.N., a consultant who has worked with nursing homes and enforcement officials in some 30 States, reported to the Committee that States vary tremendously in their commitment to imposing penalties on substandard nursing homes. The Institute of Medicine report also refers to sharp differences of opinion between States with a consultation orientation, as opposed to an enforcement approach. As long as State officials are reluctant to impose penalties on nursing homes, the enactment of a full array of penalty authorities will be insufficient in and of itself to bring about improved care in substandard nursing homes.

STAFF RECOMMENDATIONS

1. Federal legislation and improved regulation are needed to:

   o strengthen the nursing home inspection system;

   o mandate improved State response to consumer complaints and requests for inspection and cost reports;

   o require the Secretary to report to Congress within 2 years with a recommendation for a reimbursement system for Medicaid nursing home services that is based on patient mix according to severity of illness of the patients, including a recommendation for how to meet the needs of patients who will be displaced from nursing homes if reimbursement reform succeeds in improving access for a large number of heavy care patients;

   o authorize a full array of "intermediate sanction" penalties and a receivership authority, so a measured, incremental enforcement approach can be taken by inspectors, and substandard homes can be improved without relocating all the residents of these facilities;

   o elevate the nursing home residents' rights to a Condition of Participation, and strengthen these rights; make providers liable for civil penalties for certain acts of Medicaid discrimination now enforceable only as crimes;

   o strengthen the national Long Term Care Ombudsman program. Congress should mandate reporting by Ombudsman programs, and include a requirement to oversee and comment upon the adequacy of State licensing and certification offices.

2. In addition to the above legislative and regulatory changes, the following administrative actions should be undertaken:

   o HCFA should expand the hospital swing-bed program, to (1) ease the tight bed supply situation that facilitates illegal discriminatory practices; (2) increase competition in the industry, so quality can be more of a factor in the marketplace.

   o HCFA should issue instructions to the State agencies and HCFA regional offices, informing them of their obligation to enforce existing laws, such as (1) penalties for repeat offenders; and (2) prohibitions against Medicaid discrimination.

   o HCFA should promptly define what minimum items and services are meant to be provided for the basic Medicaid reimbursement rate in each State, to protect residents from loss of personal funds and to protect providers from unreasonably low reimbursement rates.

APPENDIX A:

CASE STUDIES OF CHRONICALLY SUBSTANDARD NURSING HOMES

CASE STUDY #1

LOCATION: Washington, D.C.
TYPE OF FACILITY: Skilled Nursing Facility
CURRENT STATUS: FULLY CERTIFIED

SUMMARY OF MAJOR VIOLATIONS

DEFICIENT ON REQUIREMENTS FOR MEDICAL STAFF

February 1983:
o Medical Director failed to review all incident reports involving patients
o Overall lack of proper staff training and supervision

April 1983: Missing health records for new employees

December 1983:
o Facility does not follow personnel procedures for reviews; requiring medical exams, x-rays and TB screens
o Medical Director fails to assure health, safety and well being of patients

July 1984:
o Administrator not licensed in District; no evidence that podiatrist and one nurse were licensed

June 1985: No evidence that 2 physical therapists licensed

INADEQUATE PATIENT SUPERVISION BY PHYSICIAN

April 1982:
o All patients not seen by physician at least every 30 days

January 1983: 25% records reviewed had no current physical

February 1983:
o All patients not seen by physicians as required within 48 hours of admission

December 1983:
o Physician failed to certify death for 7 hours after patient expired
o Physicians failing to sign verbal prescription orders; signing other physicans' orders

July 1984:
o 30-day reviews of total care programs by physicians don't include revised orders for activities, restraint and physical therapy; progress notes not written and signed on each visit by physician

December 1984:
o Progress notes not written and signed on each visit by physician

UNACCEPTABLE NURSING CARE

April 1982:
o Facility does not provide 24-hour nursing services sufficient to meet total needs of patients (evidenced by high number injuries from falls; 25 of 32 patients have decubitus ulcers)
o Residents in restraints not exercised to prevent contractures

January 1983:
o Patients not getting adequate 24-hour care
o Nursing care plans not complete on all residents
o Nursing personnel not taking precautions to prevent infections

February 1983:
o Nursing care plans not complete on all residents
o Patients in restraints not released as required for exercise
o Patients bathed and toiled without attention to privacy
o Incontinent patients not changed in timely manner
o Patients dressed in ill fitting or mismatched shoes, clothes; some without underwear

December 1983:
o Nursing care plans not complete on all residents
o Patients restrained without physican's order
o Nurses not recording body weights; intake and outputs; turning patients
o No evidence of routine oral hygiene being done for patients

July 1984:
o No record of turning bedridden patients and of checking, releasing, exercising patients placed in restraints;
o Physically weak patients observed in geri-chairs from breakfast until 4 PM;
o Patients not well groomed--some without underwear, shoes or socks;
o Physicians' orders for treatment not carried out.

December 1984:
o Improper preparation, record of drug administration

June 1985: Administering drugs without written prescription

ABSENCE OF REHABILITATIVE NURSING CARE

February 1983: No record of rehabilitative nursing program

December 1983: Insufficient rehabilitative program

July 1984:
o Facility lacks active program of rehabilitative nursing care (designed to help patients achieve optimal level self-care and independence)

POOR DIETARY SERVICES AND SUPERVISION

January 1983:
o Food not served at proper temperature
o Kitchen equipment not maintained in sanitary manner

February 1983:
o Insufficient supervision of staff
o Therapeutic diets improperly served
o Food stored beneath exposed water pipes; milk stored on floor
o Ceiling tiles dirty and water stained; missing wall tiles; dirty tiles throughout kitchen
o Food residue remained on plates after washing
o Fermenting garbage and water in trash compactor

December 1983:
o Staff inadquately trained to prepare therapeutic diets as ordered
o Serving utensils unsanitary
o Food spillage on food carts

February 1984:
o Floor throughout food service area dirty, coated with greasy film
o Exteriors of kitchen equipment solid with spillage
o Wall tiles streaked with spillage or coatd with greasy film
o Food stored under condensate dripping from cold water pipes
o Therapeutic diets not prepared as ordered

July 1984:
o Therapeutic menus not served as ordered (Example: diabetic diet tray had two packages of sugar)
o Intake records not maintained on patients on forced fluid diets
o Patients without teeth or dentures served regular meals (steak, apples, other "hard" food)
o Inadequately trained staff; poorly supervised food preparation
o Unsanitary conditions in dishwashing area

December 1984: Substandard food service (no temperature control)

June 1985:
o Inadequate staffing (both numbers and training)
o Therapeutic meals not served as ordered
o Substandard food service (meals late, no temperature control)
o Unsanitary conditions throughout food preparation and dishwashing areas

BADLY MONITORED ADMINISTRATION OF DRUGS

April 1982:
o Medications not administered according to physician's orders; some administered without prescription
o Physicians don't sign verbal orders; physicians write incomplete prescriptions (omit quantity and time)
o Medications stored without expiration dates and manufacturer's name

January 1983:
o Physicians don't sign verbal orders; write incomplete prescriptions

February 1983:
o Drugs carts left unlocked and unattended; drug cabinents unlocked

December 1983:
o Medications not given according to physicans orders
o Physicians don't sign verbal orders; write incomplete prescriptions; sign other physicians orders

February 1984:
o Drugs stored without proper labelling
o Numerous over-the-counter pharmaceuticals, topicals and other items found in patients' rooms with no instructions from physician for self-administration

July 1984:
o Lack written prescriptions for many drugs administered
o Medications and biologicals kept in unlabeled, unsanitary containers

December 1984:
o No documentation that pharmacist reviewed drug program of patients at least monthly
o Inadequate monitoring of entire drug program to ensure accuracy and adequacy (Note: some patients not getting prescribed medications)

June 1985:
o Lack written prescriptions for many drugs administered
o Inadequate monitoring of entire drug program to assure adequacy and accuracy (Note: physicians writing incomplete medication orders)

UNSANITARY, DETERIORATING PHYSICAL ENVIRONMENT

April 1982:
o Linens not properly sterilized
o Wheelchairs, gerichairs, furniture, bedside rails not clean, sanitary
o Insufficient staff to assure effective facility maintenance
o Roaches throughout premises

January 1983:
o Linens not properly sanitized
o Roaches throughout premises
o No records of maintenance
o Interior in bad repair--missing tiles; soiled rooms; water and air seepage around windows; floor drains clogged with debris

February 1983:
o Dirty floors, walls, tiles and other surfaces
o Dirty laundry room
o Ceiling missing in tub room; metal studs exposed in shower room
o Discarded oxygen and suction tubing, other used supplies, left in patients' rooms
o Scale and accumulated materials on bedpans
o Patients' soiled clothing on furniture, floors along with clean items
o Roaches throughout premises; rat poison in pantry

December 1983:
o Residents' rooms had srong urine or fecal odor
o Holes in walls in residents' rooms

o Leaking faucets; damaged, torn floor and wall coverings
o Water temperature not maintained
o Rotting and damaged cabinets, furniture
o Feces and urine on commodes;
o Dirty linen mixed with clean
o Dirty syringes used for tube feedings; oral and rectal thermometers stored together
o Inadequate staff in laundry and maintenance
o Basic infection control procedures not adequate

February 1984:
o Wall covering stained, torn; floor patched with plastic tape; molding peeling from room walls
o Holes in walls in residents' rooms
o Roaches throughout premises
o Unsanitary bedpans stored with residents' clean clothing
o Fecal odor in rooms and closets
o Carts for collecting and delivering linen grossly soiled

July 1984:
o No documentation of maintenance on equipment
o Dirty floors, furnishings, light fixtures

December 1984:
o Dirty floors, furnishings, light fixtures
o Damaged/missing floor coverings, wall and ceiling tiles, baseboards
o Soiled and clean clothing stored together in plastic bags on floor
o Damaged windows; damaged bathroom hardware

June 1985:
o Inadequate lighting and ventilation, lose electrical fixture
o Sinks separating from foundation, window hardware coming lose
o Wall and floor coverings damaged/missing
o Bedrails not secured; check of drawers not stabalized
o Suction machines not cleaned after each use

CASE STUDY #2

LOCATION: San Francisco, California area
TYPE OF FACILITY: Skilled Nursing Facility (SNF)
CURRENT STATUS OF FACILITY: FULLY CERTIFIED

SUMMARY OF MAJOR VIOLATIONS

DEFICIENT ON REQUIREMENTS FOR MEDICAL STAFF

September 1981:
o Social Service director not qualified
o 11 of 12 new employees without physical and TB screening

October 1982:
o Administrator fails to enforce rules and regulations to protect health and safety of patients
o 75% employees without current physical and TB screening

December (Revisit): Standard still not met

July 1984:
o Administrator failed to do required evaluations of adequacy of health professional services

March 1985:
o Administrator fails to rules and regulations basic to health and safety of patients
o Cook, laundry supervisor not qualified for jobs
o Inadequate number of personnel employed
o Nurse assistants lack proper in-service education

INADEQUATE PATIENT SUPERVISION BY PHYSICIAN

October 1982:
o Patients not seen by physician at least every 30 days
o Progress/orders notes inadequate to give picture of patients conditions and needs

July 1984:
o Patients not seen by physican at least every 30 days
o Physican failed to respond to changes in patients conditions with new programs for care
o Progress/orders notes inadequate to give picture of patients conditions and needs

March 1985:
o Patients not seen by physician at least every 30 days
o Emergency phone numbers for physicians not posted

UNACCEPTABLE NURSING CARE

September 1981:
o Designated charge nurse not qualified
o No long term goals for nursing care plans
o Not sufficient number of nurses for proper patient care

October 1982:
o 24-hour nursing care not provided
o Patients not well groomed--lax oral care; scaly, dry skin
o Patients left restrained for hours without position change or toileting
o Plans for patient care not developed and adequate records of care kept
o Physicians not notified promptly of laboratory results

December 1982 (Revisit):
o Still no procedure for notifying physician when decubiti (bedsores) first appear
o Still lack plans for patient care and adequate records

July 1984:
o Failure to monitor patients with eye and skin conditions
o Failure to notify kitchen of new diet requirements and to serve therapeutic diets correctly
o No nurse supervisor on each shift
o Patients left unattended in restraints for long periods
o Patients records lack data necessary to give clear picture of progress/problems

October 1984 (Complaint):
o Patient transferred to acute hospital without notification of family until two days later
o Medication not administered as prescribed by doctor
o No record of patient's fall and resulting problems

March 1985:
o Nurses failed to notify physician immediately regarding sudden or marked adverse change in patients' conditions (Examples: patients with staph infections; patients with first occurrance of decubitus ulers; patient with pneumonia; patient given wrong medication which was life threatening)
o Daily rounds did not include visits with all patients
o No nurse supervisor on each shift
o 24-hour nursing service not provided (catheters not changed; contaminated pads and needles not removed; infection control procedures not implemented; vital signs not taken)
o Patients not well groomed--feces and urine on skin; needed shaves; teeth not cleaned; offensive odors
o Vital signs/test not taken regularly and recorded
o Health records show no evidence of continuing assessment of patients' needs by all concerned professionals.

September 1985 (Investigation):
o Urinary tract infection untreated, with patient subsequently admitted to an acute care facility

o Decubitus ulcer (bedsore) documented as healed, then identified in advanced stage 12 days later
o Patient's nutritional needs not asessed for four-month period during which four decubitus ulcers appeared
o Decubitus ulcer on patient not noted on care plan for one week

ABSENCE OF REHABILITATIVE NURSING CARE

September 1981:
o Rehabilitative nursing care not being carried through

October 1982:
o Facility lacks active program of rehabilitative nursing care, designed to help patients achieve optimal level of self-care and independence

December (Revisit): Rehabilitative program still not initiated

March 1985:
o Facility lacks active program of rehabilitative nursing care, designed to help patients achieve optimal level of self-care and independence (patients not kept active and out of bed;
o incontinent patients not given bowel/bladder management program;
o restraints and postural supports applied without supervision, improperly without concern for circulation)

POOR DIETARY SERVICES AND SUPERVISION

September 1981:
o Food not stored, prepared or served under sanitary conditions
o Kitchen equipment not in good working order

October 1982:
o Diet manual not approved by dietitian
o Inadequately trained staff
o Special diet trays not controlled (salt on sodium restricted trays).

December (Revisit):
o Special diet trays still not prepared and delivered as ordered

July 1984:
o Food not served at proper temperature
o Special diet trays not controlled (salt on sodium restricted trays)

March 1985:
o Meals not adequate for nutritional needs of patients
o Patients not assured necessary fluids for hydration
o Patients needing assistance in eating not getting it
o Inadequately trained staff
o Facility failed to cook enough food, delivered food late, served without appropriate eating utensils.

BADLY MONITORED ADMINISTRATION OF DRUGS

September 1981:
o Drugs and treatments not given as prescribed
o Drugs administered by unlicensed person
o Employees unable to identify all patients before giving drugs.

February 1982: Sufficient medical supplies not available

October 1982:
o Medications not administered as prescribed
o Dose/time drug given not always recorded
o Lack written prescriptions for many verbal orders
o Inadequate monitoring of controlled drugs

December (Revisit):
o Dose/time drug given still not consistently recorded
o Still no procedures to assure medications administered as prescribed

July 1984:
o Drugs stored at wrong temperatures
o Inadequate supplies of emergency medications
o Drugs given after stop orders issued

March 1985:
o Medications not administered as prescribed
o Prescription medications administered without order of person lawfully authorized to prescribe
o Drugs stored without labeling; contaminated or deteriorated drugs were available for use; drugs were accessible to other than authorized personnel
o Anti-infectives and drugs used to treat severe pain, nausea, agitation, diarrhea or other severe discomformt not available and administered within 4 hours of time ordered

UNSANITARY, DETERIORATING PHYSICAL ENVIRONMENT

September 1981:
o No records of equipment maintenance
o Furniture, windows, shower rooms need cleaning, repair
o Insufficient linen (torn blankets for face cloths; sheets used as bath towels)

October 1982:
o Facility overall not clean, sanitary and in good condition
o Ceilings and walls need repair and paint
o All furniture in patients' rooms need cleaning, repair
o Soiled egg crates found in patients' closets, clothing piled on tables
o Water heaters malfunction
o Used urinals and bedpans left in rooms; water fountains soiled; no soap, toilet paper and towels missing from some bathrooms
o No supervision of maintenance staff

o Inadequate provisions for cleaning, disinfecting or contaminated areas

December 1982 (Revisit):
o Ceilings and walls need repair, cleaning and paint
o Furniture needs cleaning and repair
o Draperies need repair and proper hanging
o Inadequate provisions for cleaning, disinfecting of contaminated areas

July 1984:
o Walls soiled; floor tiles chipped; paint in corridor incomplete
o Building eaves dented, exterior paint scarred and patched

March 1985:
o No documentation to show equipment regularly maintained
o Dirty floors and walls; sticky handrails; hole in wall; soiled drapes and furniture; bathroom floors badly stained with urine odor;
o Hot water temperature controls not working
o Inadequate provisions for cleaning, disinfecting of contaminated areas; no provisions for isolating patients with infectious diseases

CASE STUDY #3

LOCATION: Georgia
TYPE OF FACILITY: Skilled Nursing Facility

SUMMARY OF MAJOR VIOLATIONS

INADEQUATE PATIENT SUPERVISION BY PHYSICIAN

April 1984:
o Restraints were placed on patients without physician's orders.
o Physician's signatures on verbal orders provided to nurses, had not been countersigned within 48 hours.

September 1984:
o Problems as stated in the patient care plans are not specific, so that, the actual patient problem or need is not always identified.

UNACCEPTABLE NURSING CARE

April 1983:
o Inadequate nursing services to meet patient requirements, i.e., tests were not performed as ordered by the physician, poor maintenance of patient medical records, privacy curtains were not used by nursing personnel to ensure privacy for the patient, bowel and bladder retraining programs were not adequately documented, failure to document the administration of drugs, and linens were not properly handled.
o Inadequate levels of nursing personnel were available to feed patients during the meal service.

July 1983:
o Rehabilitative nursing is not an integral part of nursing as demonstrated by the improper use of restraints; absence of nursing personnel to assist patients while dining and lack of needed silverware to help patients reach an optimal level of self-care in feeding.
o Nursing personnel are not aware of the nutritional needs of the patients.
o Drugs are not being administered in accordance with physician's orders.
o Twenty-eight doses of a common drug were administered in error before being stopped.
o Poor monitoring of patient care; one patient requiring close monitoring, had not had his vital signs taken for four days.

April 1984:
o Inadequate nurse supervision by the charge nurse, has resulted in restraints on patients, not being appropriately checked and released.

o Over 90 incontinent patients have not been assessed to determine if they would benefit from a bowel and bladder re-training program.

July 1984:
o In accordance with the facilities own procedures, patients are not receiving baths as required.

April 1985:
o Significant changes in patient health care, such as receiving a major head injury, was not reported to the physician, nor the patient's family.
o Pertinent information concerning the patient's recovery, was not documented by the charge nurse, into the medical record.
o Documentation of patient injuries and the examination by the physician assistant, were not appropriately recorded.
o Patient care plans are not being reviewed, evaluated and updated as the status of the patient changes.
o Inadequate nursing personnel are available to assist patients during feeding.
o Failure of the charge nurses to delegate responsibilities to other nursing personnel, has resulted in vital information concerning patient care, not being provided to assistants working with the patient (i.e., seizure potential, diabetic, blindness, use no soap, (keep) feet elevated at all times, etc.).

October 1985:
o Treatment of patients is rendered without consideration, respect and full recognition of their dignity and individuality, i.e., lack of privacy, male patients unshaven, patients in bed without clothing and exposed, patient's diaper being changed without privacy curtains being used or the door closed, patients sitting and lying in their own feces and urine.
o Insufficient number of qualified personnel to meet total nursing needs and to ensure that patients receive treatments and medications as prescribed.

POOR DIETARY SERVICES AND SUPERVISION

July 1983:
o According to residents, meals are often cold when they receive their trays.
o Non-hygenic food handling techniques are used by the facility staff.
o Infestation of flies in the dining area, which were alighting on patient's food.

April 1984:
o Assistance is not provided to patients needing it during meal services.
o Therapeutic and restricted diet menus were not prepared as instructed.
o Dietetic services staff lacked proper training.

September 1984:

o Tuberculosis testing of dietary employees had not been performed, as required.

January 1985:
o Baths are not provided to patients as frequently, as needed. Also partial baths are not given in between the twice a week complete baths.
o Call lights are not answered promptly, as reported in 5 out of 10 patient interviews.

BADLY MONITORED ADMINISTRATION OF DRUGS

April 1983:
o Inadequate documenation on the administration of drugs to patients.

July 1983:
o Failure to administer drugs inaccordance with physician's instructions.

April 1984:
o Improper documentation on 75% of the medication administration records, indicating that patients received too few or too many doses.

October 1985:
o There were omissions on the patient's medication administration record where the nurse failed to appropriately document the administration of medications.

UNSANITARY, DETERIORATING ENVIRONMENT

April 1983:
o Unsanitary procedures are followed in the handling of linens.

July 1983:
o Insufficient supply of linen.
o Clean towels had the odor of feces.
oInfestation of roaches and flies.

July 1984:
o Inadequate supplies of linen, existed throughout the facility.

January 1985:
o Additional towels and face cloths are needed to meet the needs of patients.
o Insufficent janitorial services, i.e., floors and bathrooms needed cleaning, urine odors permeated the area, and bed side commodes were not being cleaned and emptied after use.

April 1985:
o Dirty and clean linens were not keep separated.

October 1985:

o Each patient did not have an individual towel and face cloth.
o Soiled linens were left lying around and linens were not handled in such a manner as to prevent infection.
o Large infestation of roaches exist at the facility.
o Unsanitary facilities, bath rooms not properly cleaned, severe build up of dirt, grime and wax along the walls and dried feces on toilet stools. General shower and bath facilities were used to store unused chairs, boxes, coat hangers and unserviceable material.

CASE STUDY #4

LOCATION: WASHINGTON, D.C.
TYPE OF FACILITY: SKILLED NURSING FACILITY

SUMMARY OF MAJOR VIOLATIONS

UNACCEPTABLE NURSING CARE

MARCH 1983:
o Lack of conformance with written procedures, in reporting significant changes in patient health status to relatives.

MAY 1984:
o Failure to promptly notify the family of patient's death; family informed of death three days later.

DEFICIENT CONCERN FOR PATIENT WELFARE

MARCH 1983:
o Violations of residents rights and examples of mistreatments observed: 1) facility fails to provide diversional activities commensurate with the residents interest, abilities and goals in order to enhance feelings of involvement and self-respect 2) insufficient access to the handicapped telephone for wheelchair bound patients 3) privacy curtains missing on toilet stalls.
o Financial accounts are maintained for residents without required written authorizations.

MAY 1985:
o Failure to provide patients with regular financial accounting, of transactions made in their behalf.

JANUARY 1986:
o Insufficent documentation to evidence that patients and/or their guardians are provided a financial accounting for patient funds.

PHARMACEUTICAL SERVICES

APRIL 1982:
o Failure of the consultant pharmacist to provide appropriate procedures for dispensing and administration of drugs and biologicals.
o Medications were improperly labeled.
o Lack of existence of the Pharmaceutical Services Committee, as required by Federal regulations.

MARCH 1983:
o Lack of compliance with Federal regulations regarding membership on the Pharmaceutical Services Committee.

MAY 1984:
o Inadequate monitoring of the entire drug program:

MAY 1985:

o Pharmaceutical Services Committee did not monitor services to assure accuracy and adequacy: (a) physicians failed to date and countersign telephone orders, (b) failure to administer medications to patients, (c) medications administered after the scheduled treatment time.

APPENDIX B

RESULTS OF COMMITTEE STAFF ANALYSIS OF NURSING HOME INSPECTION REPORTS

STATE (Total SNFs)	SNFs with less than 3 DEFICIENCIES 1984 #	(%)	SNFs with 3 or more DEFICIENCIES 1984 #	(%)	TOTAL SNFs DEFICIENT 1984* #	(%)	SNFs CHRONICALLY DEFICIENT 1980-85** #	(%)
ALABAMA (193)	72	(37%)	65	(34%)	137	(71%)	33	(17%)
ALASKA (9)	2	(22%)	2	(22%)	4	(44%)	0	
ARIZONA (49)	12	(25%)	2	(4%)	14	(28%)	0	
ARKANSAS (132)	44	(33%)	37	(28%)	81	(61%)	35	(26%)
CALIFORNIA (1,165)	472	(40%)	239	(20%)	711	(61%)	141	(12%)
COLORADO (156)	36	(23%)	15	(10%)	51	(83%)	12	(9%)
CONNECTICUT (209)	88	(42%)	46	(22%)	134	(64%)	34	(16%)
DELAWARE (25)	7	(28%)	1	(4%)	8	(32%)	0	
WASHINGTON, DC (8)	3	(37%)	1	(12%)	4	(50%)	0	
FLORIDA (409)	61	(15%)	20	(5%)	81	(20%)	6	(1%)
GEORGIA (261)	71	(27%)	42	(16%)	113	(43%)	29	(11%)
HAWAII (27)	4	(15%)	0		4	(15%)	0	
IDAHO (59)	18	(30%)	1	(2%)	19	(32%)	1	(2%)
ILLINOIS (466)	84	(18%)	3	(1%)	87	(19%)	2	(1%)

STATE (Total SNFs)	SNFs with less than 3 DEFICIENCIES 1984 #	(%)	SNFs with 3 or more DEFICIENCIES 1984 #	(%)	TOTAL SNFs DEFICIENT 1984* #	(%)	SNFs CHRONICALLY DEFICIENT 1980-85** #	(%)
INDIANA (197)	23	(12%)	11	(6%)	34	(17%)	31	(16%)
IOWA (41)	5	(12%)	3	(7%)	8	(20%)	1	(2%)
KANSAS (66)	23	(35%)	15	(23%)	38	(58%)	10	(15%)
KENTUCKY (93)	9	(10%)	5	(5%)	14	(15%)	0	
LOUISIANA (32)	3	(11%)	2	(6%)	5	(16%)	0	
MAINE (19)	2	(11%)	0		2	(11%)	0	
MARYLAND (116)	40	(34%)	13	(11%)	53	(46%)	2	(2%)
MASSACHUSETTS (337)	42	(12%)	21	(6%)	63	(19%)	5	(2%)
MICHIGAN (300)	70	(23%)	25	(8%)	95	(32%)	12	(4%)
MINNESOTA (371)	23	(6%)	1	(.3%)	24	(6%)	0	
MISSISSIPPI (134)	57	(43%)	40	(30%)	97	(72%)	19	(14%)
MISSOURI (227)	47	(21%)	31	(14%)	78	(34%)	10	(4%)
MONTANA (83)	25	(30%)	4	(5%)	29	(35%)	0	
NEBRASKA (39)	19	(49%)	3	(8%)	22	(56%)	1	(3%)

STATE (Total SNFs)	SNFs with less than 3 DEFICIENCIES 1984 #	(%)	SNFs with 3 or more DEFICIENCIES 1984 #	(%)	TOTAL SNFs DEFICIENT 1984* #	(%)	SNFs CHRONICALLY DEFICIENT 1980-85** #	(%)
NEVADA (26)	3	(12%)	22	(85%)	25	(96%)	17	(65%)
NEW HAMPSHIRE (22)	1	(5%)	0		1	(5%)	0	
NEW JERSEY (245)	107	(44%)	60	(25%)	167	(68%)	39	(16%)
NEW MEXICO (14)	4	(29%)	0		4	(29%)	0	
NEW YORK (558)	45	(8%)	40	(7%)	85	(15%)	20	(4%)
NORTH CAROLINA (175)	47	(27%)	6	(3%)	53	(30%)	5	(3%)
NORTH DAKOTA (59)	29	(49%)	19	(32%)	48	(81%)	8	(14%)
OHIO (449)	41	(9%)	11	(2%)	52	(12%)	2	(.4%)
OKLAHOMA (12)	3	(25%)	0		3	(25%)	0	
OREGON (67)	11	(16%)	2	(3%)	13	(19%)	1	(2%)
PENNSYLVANIA (579)	82	(14%)	17	(3%)	99	(17%)	6	(1%)
PUERTO RICO (4)	2	(50%)	0		2	(50%)	0	
RHODE ISLAND (65)	9	(14%)	1	(2%)	10	(15%)	0	
SOUTH CAROLINA (104)	24	(23%)	10	(10%)	34	(33%)	3	(3%)

STATE (Total SNFs)	SNFs with less than 3 DEFICIENCIES 1984 #	(%)	SNFs with 3 or more DEFICIENCIES 1984 #	(%)	TOTAL SNFs DEFICIENT 1984* #	(%)	SNFs CHRONICALLY DEFICIENT 1980-85** #	(%)
SOUTH DAKOTA (67)	27	(40%)	22	(33%)	49	(73%)	16	(24%)
TENNESSEE (85)	14	(16%)	5	(6%)	19	(22%)	4	(5%)
TEXAS (239)	31	(13%)	9	(4%)	40	(17%)	5	(2%)
UTAH (45)	14	(31%)	22	(49%)	36	(80%)	17	(38%)
VERMONT (21)	3	(14%)	0		3	(14%)	0	
VIRGINIA (79)	9	(11%)	2	(3%)	11	(14%)	0	
WASHINGTON (245)	114	(47%)	74	(30%)	188	(77%)	47	(19%)
WEST VIRGINIA (41)	14	(34%)	7	(17%)	21	(51%)	3	(7%)
WISCONSIN (385)	44	(11%)	6	(2%)	50	(13%)	1	(.3%)
WYOMING (22)	9	(41%)	4	(18%)	13	(59%)	2	(9%)
NATIONAL TOTALS (8852)	2049	(23%)	987	(11%)	3036	(34%)	582	(7%)

* represents skilled nursing facilities in violation of one or more of 24 critical health, safety and quality standards.

** represents skilled nursing facilities in violation of at least three critical conditions in at least three of the last four inspections.

APPENDIX C

INCREASES IN VIOLATIONS OF CRITICAL STANDARDS AND REQUIREMENTS FOR MINIMALLY ACCEPTABLE NURSING HOME CARE (1982 TO 1984)

Standard	Number of Violations		
	1982	1984	% Increase
PATIENTS DISCHARGED OR EVICTED FROM FACILITY WITHOUT LEGITIMATE REASON	49	98	+ 100%
PATIENTS DISCOURAGED/PROHIBITED, WITH THREAT OF REPRISAL, FROM EXERCISING THEIR RIGHTS	36	60	+ 66%
PATIENTS SUBJECTED TO MENTAL, PHYSICAL AND/OR CHEMICAL (DRUG) ABUSE	375	656	+ 75%
FACILITY FAILED TO PROVIDE ADEQUATE PHYSICIAN SUPERVISION OF PATIENTS	73	128	+ 75%
FACILITY FAILED TO PROVIDE ADEQUATE 24-HOUR NURSING CARE	181	292	+ 61%
FAILURE OF FACILITY TO PROVIDE ADEQUATE REHABILITATIVE NURSING CARE	625	954	+ 53%
FAILURE OF FACILITY TO MEET PATIENTS' NUTRITION AND FEEDING NEEDS	176	338	+ 92%
INADEQUATE CONTROLS AND RECORD-KEEPING FOR ADMINISTRATION OF DRUGS	100	145	+ 45%
FAILURE TO ADMINISTER DRUGS ACCORDING TO PHYSICIAN'S ORDERS	213	301	+ 41%
AGGREGATE TOTALS	**1828**	**2972**	**+ 63%**

APPENDIX D

SENATE SPECIAL COMMITTEE ON AGING

SELECTED KEY CONDITIONS, STANDARDS AND ELEMENTS FOR COMPLIANCE

BY SKILLED NURSING FACILITIES

F15. Condition II -- The Skilled Nursing Facility (SNF) has an effective governing body, or designated persons so functioning, with full legal authority and responsibility for the operation of the facility.

F62. Standard: Patients' rights. -- The governing body of the facility establishes written policies regarding the rights and responsibilities of patients.

F70 Element: Patient is transferred or discharged for legitimate reasons (medical, welfare of other patients) and is given reasonable advance notice.

F71 Element: Patient is encouraged and assisted to exercise his/her rights (voice grievances and recommend changes without interference, discrimination and reprisal).

F73 Element: Patient is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized by a physician (for limited time) or when necessary for protection of the patient and others.

F101 Condition IV. -- Physician Services. Patients are admitted only upon recommendation of, and remain under the care of, a physician.

F105 Standard: Patient Supervision By Physician.

F111 Element: Patient's total program of care (drugs & treatments) is reviewed by a physician every 30 days for the first 90 days, and revised as necessary.

F112 Element: A progress note is written and signed by the physician on each visit, and the physician signs all orders.

F123 Condition V. -- Nursing Services. The SNF provides 24-hour service by licensed nurses (services of an RN at least during the day tour of duty 7 days a week. There are enough nurses to meet the total nursing needs of all patients.

F134 Standard: Twenty-four-hour nursing service.

F135 Element: 24-hour nursing services to meet total nursing needs.

F136 Element: nursing policies ensure that each patient receives treatments, medications, and diet as prescribed, and rehabilitative nursing as needed; receives proper care to prevent decubitus ulcers and deformities, and is kept comfortable, cleaned, well-groomed, and protected from accident, injury, and infection.

F173 Standard: Rehabilitative Nursing Care.

F175 Element: an active program of rehabilitative nursing care and is directed toward each patient achieving and maintaining an optimal level of self-care and independence.

F176 Element: Rehabilitative nursing care services are performed daily for those patients who require it, and are recorded routinely.

F177 Standard: Supervision Of Patient Nutrition.

F178 Element: Nursing personnel are aware of the nutritional needs and food and fluid intake of patients and assist where needed in feeding patients.

F180 Element: Food and fluid intake of patients is observed, and deviations from normal are recorded and reported to the charge nurse and physician.

F181 Standard: Administration Of Drugs.

F182 Element: Drugs and biologicals are administered only by physicians, licensed nursing personnel, or by personnel with State-approved training.

F186 Element: administration of a drug is properly recorded by the person administering.

F189 Standard: Conformance with physicians' drug orders.

F190 Element: Drugs are administered according to written orders of the physician.

F191 Element: Drugs not specifically limited as to time or number of doses when ordered are controlled by automatic stop orders or other methods in accordance with written policies.

APPENDIX E

SENATE SPECIAL COMMITTEE ON AGING

SELECTED KEY STANDARDS AND ELEMENTS FOR COMPLIANCE

BY INTERMEDIATE CARE FACILITIES

XII. PHYSICIAN SERVICES

T94 Standard: Physician Services. The facility assures that each resident's health care is under the continuing supervision of a physician who sees the resident at least once every 60 days, unless justified otherwise.

XIII. HEALTH SERVICES

T95 Standard: Health Services. The facility provides health services which assure that each resident receives treatments, medications, diets, and other health services as prescribed and planned.

T103 Standard: Health Care Plan. A written health care plan is developed and implemented by appropriate staff for each resident.

T105 Standard: Nursing Service. Nursing services, including restorative nursing, are provided in accordance with the needs of the residents.

XIV. DIETETIC SERVICES

T117 Standard: Sanitary Conditions. All food is procured, stored, prepared, distributed, and served under sanitary conditions.

T118 Standard: Self-Help Devices. Individuals needing special equipment, implements, or utensils to assist them when eating have such items provides.

XV. DRUGS AND BIOLOGICALS

T127 Standard: Automatic Stop Orders. Medications not specifically limited as to time or number of doses when ordered are controlled by automatic stop orders or other methods in accordance with written policies and the attending physician is notified.

T129 Standard: Medication Review. A registered nurse reviews monthly each resident's medications and notifies the physician when changes are appropriate.

XVI. RESIDENT RECORD SYSTEM

T135 Standard: Content. There is a record for each resident.

T139 Element: The record contains assessments and goals of each service's plan of care and modifications.

T143 Element: The record contains entries describing treatments and services rendered.

T144 Element: The record contains entries on medications administered.

XVIII. ENVIRONMENT AND SANITATION

T152 Standard: The facility maintains adequate conditions relating to environment and sanitation.

T163 Element: Temperatures of hot water at plumbing fixtures used by residents is automatically regulated by control valves.

T164 Element: Corridors used by residents are equipped with firmly secured handrails.

T165 Element: Provision is made for isolating residents with infectious diseases.

T169 Standard: Facilities for Physically Handicapped. The facility is accessible to and functional for residents, personnel, and the public.

APPENDIX F

DHHS Inspector General

Selected Key Conditions, Standards and Elements for Compliance

by Skilled Nursing Facilities

Selected Conditions of Participation

Medical Direction
Physician Services
Nursing Services
Dietetic Services
Pharmaceutical Services
Physical Environment (includes Life Safety Code)
Infection Control

Selected Standards

Physician Services

Patient supervision by physician
Availability of physicians for emergency patient care

Nursing Services

Director of nursing services
Charge nurse
24 hour nursing service
Patient care plan
Rehabilitative nursing care
Supervision of patient nutrition
Administration of drugs
Conformance with physician drug orders
Storage of drugs and biologicals

Dietetic Services

Staffing
Menus and nutritional adequacy
Therapeutic diets
Frequency of meals
Preparation and service of food
Hygiene of staff
Sanitary conditions

Pharmaceutical Services

Supervision of services
Control and accountability
Labeling of drugs and biologicals

Physical Environment

Emergency power
Nursing unit
Facilities for special care
Maintenance of equipment, buildings, and grounds.